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2000STATE OF ILLINOIS DEPARTMENT OF PUBLIC AID FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES (FISCAL YEAR 2000)

IMPORTANT NOTICE

THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

	IDDH E. 224 ID V 0000771		H CEDTI	ELCATION BY AUTHODIZED EACH ITY OFFICED
1.	IDPH Facility ID Number: 0000661		II. CERTI	FICATION BY AUTHORIZED FACILITY OFFICER
	Facility Name: FORD COUNTY NURSING HOME			
	Address: RR2 1240 N MARKET STREET PAXTON	60957		ve examined the contents of the accompanying report to the fillinois, for the period from 12/01/99 to 11/30/00
	Number City	Zip Code		tify to the best of my knowledge and belief that the said content:
	County: FORD			ble instructions. Declaration of preparer (other than provider)
	Telephone Number: (217)379-4896 Fax # ()		is base	d on all information of which preparer has any knowledge
				ntional misrepresentation or falsification of any information
	IDPA ID Number: <u>376000821</u>		in this	cost report may be punishable by fine and/or imprisonment
	Date of Initial License for Current Owners: 1946			(Signed)
	Type of Ownership:		Officer or Administrator	(Type or Print Name)
	Type of Ownership.		of Provider	(Type of Trint Name)
	VOLUNTARY,NON-PROFIT PROPRIETARY XX	GOVERNMENTAL	or rroyaucr	(Title) Administrator
	Charitable Corp. Individual	State		
		XX County		(Signed)
	IRS Exemption Code Corporation	Other	D : 1	(Date)
	"Sub-S" Corp. Limited Liability Co.		Paid Preparer	(Print Name and Title) CRAIG L. ATER
	Trust		Перагег	and Title) CRAIG L. ATER
	Other			(Firm Name
				& Address) Heritage Enterprises
				(Telephone) (309)823-7135 Fax # () MAIL TO: OFFICE OF HEALTH FINANCE
	In the event there are further questions about this report, please contact:			ILLINOIS DEPARTMENT OF PUBLIC AID
	Name: CRAIG L. ATER Telephone Number: (309)82	23-7135		201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630

DPA 3745 (N-4-99) IL478-2471

STATE OF ILLINOIS Page 2

acility Name & ID Numb	er FORD COU	NTY NURSING HO	ME			# 0000661 Report Period Beginning: 12/01/99 Ending: 11/30/00
III. STATISTICA	L DATA					D. How many bed-hold days during this year were paid by Public Aid?
A. Licensure/o	certification level(s) o	f care; enter number	of beds/bed days,			(Do not include bed-hold days in Section B.)
(must agree	with license). Date of	change in licensed b	eds			·
(8	,		_		-	E. List all services provided by your facility for non-patients.
1	2		3	4		(E.g., day care, "meals on wheels", outpatient therapy)
			1	1		NONE
Beds at				Licensed		
Beginning of	Licensu	re	Beds at End of	Bed Days During		F. Does the facility maintain a daily midnight census?
Report Period	Level of		Report Period	Report Period		125
Keport i eriou	Level of	Care	Report 1 eriou	Report 1 eriou		G. Do pages 3 & 4 include expenses for services or
1 69	Skilled (SN	E)	69	25 105	1	investments not directly related to patient care?
1 69		atric (SNF/PED)	69	25,185	2	YES NO XX
3	Intermediat	. ,		0	3	TEO NO MA
4	Intermediat	()		•	4	H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
5	Sheltered C			0	5	YES NO XX
6	ICF/DD 16				6	
						I. On what date did you start providing long term care at this location?
7 69	TOTALS		69	25,185	7	Date started 1946
B. Census-For	the entire report per	riod.				J. Was the facility purchased or leased after January 1, 1978? YES Date NO XX
1	2	3	4	5		
Level of Care	Patient Days	by Level of Care and	d Primary Source of	f Payment		K. Was the facility certified for Medicare during the reporting year?
	Public Aid					YES NO XX If YES, enter number
	Recipient	Private Pay	Other	Total		of beds certified 0 and days of care provided
8 SNF	16,530	5,145	0	21,675	8	
9 SNF/PED					9	Medicare Intermediary
10 ICF					10	
11 ICF/DD					11	IV. ACCOUNTING BASIS
12 SC	0	0	0		12	MODIFIED
13 DD 16 OR LESS					13	ACCRUAL XX CASH* CASH*
14 TOTALS	16,530	5,145		21,675	14	Is your fiscal year identical to your tax year? YES XX NO
	cupancy. (Column 5, n line 7, column 4.)	line 14 divided by to 86.06%	etal licensed			Tax Year: 11/30/00 Fiscal Year: 11/30/00 * All facilities other than governmental must report on the accrual basis.

	G/L	RECAP CENSUS D	IFF
PP	5145	5145	0
IPA	16530	16530	0
medicare	25254	0	25254
	46929	21675	
IPA BEDHOLDS	0		
PP BEDHOLDS	0		
PP CONVERS	0		

IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES

STATE OF ILLINOIS

Page 3

29

Facility Name & ID Number FORD COUNTY NURSING HOME 0000661 **Report Period Beginning:** 12/01/99 **Ending:** 11/30/00 # V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar) Costs Per General Ledger Reclassified Adjust-FOR OHF USE ONLY Reclass-Adjusted Salary/Wage **Operating Expenses** Supplies Other Total ification Total ments Total A. General Services 3 5 10 2 6 8 230,700 1 Dietary 212,678 18,022 230,700 0 230,700 65,369 2 Food Purchase 65,369 65,369 65,369 0 2 74,881 8,943 83,824 83,824 83,824 3 Housekeeping 0 3 4 Laundry 16,521 1,470 17,991 17,991 0 17,991 4 5 Heat and Other Utilities 63,223 63,223 63,223 63,223 0 5 73,247 73,247 33,633 24,584 15,030 73,247 Maintenance 6 Other (specify):* 7 8 TOTAL General Services 337,713 118,388 78,253 534,354 534,354 534,354 8 B. Health Care and Programs 1.950 1,950 1,950 9 Medical Director 1,950 0 9 10 Nursing and Medical Records 744,057 62,090 154,034 960,181 960,181 0 960,181 10 10a Therapy 104 144 248 (144)104 0 104 10a 11 Activities 40,277 1.145 109 41,531 41,531 0 41,531 11 12 Social Services 20,426 26,126 26,126 26,126 5,700 0 12 13 Nurse Aide Training 1,000 1,000 1,000 1,000 0 13 14 Program Transportation 0 14 15 Other (specify): 0 15 16 TOTAL Health Care and Programs 804,760 64,339 161,937 1,031,036 (144)1,030,892 1,030,892 16 C. General Administration 17 Administrative 49,173 49,173 49,173 49,173 0 17 18 Directors Fees 0 18 119,589 19 Professional Services 119,589 119,589 0 119,589 19 20 Dues, Fees, Subscriptions & Promotions 54,154 (37,778)16,376 (4,436) 11,940 54,154 20 21 Clerical & General Office Expenses 51,353 51,353 51,353 34,211 8,739 8,403 0 21 22 Employee Benefits & Payroll Taxes 127,192 127,192 216,995 344,187 127,192 22 23 Inservice Training & Education 360 360 360 0 360 23 6,009 (4,010)24 Travel and Seminar 6,009 6,009 1,999 24 25 Other Admin, Staff Transportation 25 0 26 Insurance-Prop.Liab.Malpractice 240 240 240 0 240 26 27 Other (specify):* 47,887 47,887 47,887 (47.071)816 27 28 TOTAL General Administration 83,384 8,739 363,834 455,957 (37,778)418,179 161,478 579,657 28

2,021,347

(37,922)

1,983,425

161,478

2,144,903

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

191,466

1,225,857

Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000

604,024

Print Previe

IOTAL Operating Expense

(sum of lines 8, 16 & 28)

STATE OF ILLINOIS

Page 4

Facility Name & ID Number FORD COUNTY NURSING HOME # 0000661 Report Period Beginning: 12/01/99 Ending: 11/30/00

V. COST CENTER EXPENSES (continued)

			Cost Per Gener	al Ledger		Reclass-	Reclassified	Adjust-	Adjusted	FOR OHF	USE ONLY	
	Capital Expense	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			18,000	18,000		18,000	0	18,000			30
31	Amortization of Pre-Op. & Org.							0				31
32	Interest			(1,593)	(1,593)		(1,593)	1,593				32
33	Real Estate Taxes			0				0				33
34	Rent-Facility & Grounds							0				34
35	Rent-Equipment & Vehicles			411	411		411	(368)	43			35
36	Other (specify):*							0				36
37	TOTAL Ownership			16,818	16,818		16,818	1,225	18,043			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation							0				38
39	Ancillary Service Centers					144	144	0	144			39
40	Barber and Beauty Shops	0	428	0	428		428	0	428			40
41	Coffee and Gift Shops							0				41
42	Provider Participation Fee					37,778	37,778	0	37,778			42
43	Other (specify):*							0				43
44	TOTAL Special Cost Centers		428		428	37,922	38,350		38,350			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	1,225,857	191,894	620,842	2,038,593	0	2,038,593	162,703	2,201,296			45

^{*}Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

Facility Name & ID Number VI. ADJUSTMENT DETAIL FORD COUNTY NURSING HOME

STATE OF ILLINOIS

Report Period Beginning:

12/01/99

Page 5

Ending:

11/30/00

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

0000661

	In column 2 below, refe	rence the line on w	hich the	particular cost v	vas in
		1	2 Refer-	OHF USE	
	NON-ALLOWABLE EXPENSES	Amount	ence	ONLY	
1	Day Care \$	Amount	ence	S	1
2	Other Care for Outpatients			3	2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5		(2(0)	25		5
	Telephone, TV & Radio in Resident Rooms	(368)	35		
6	Rented Facility Space	0	34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	0	30		9
10	Interest and Other Investment Income	1,593	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	0	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		24		16
17	Non-Care Related Fees	0	20		17
18	Fines and Penalties				18
19	Entertainment	(4,010)	24		19
20	Contributions	0	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	0	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(47,071)	27		24
25	Fund Raising, Advertising and Promotional	(4,436)	20	1	25
	Income Taxes and Illinois Personal	())		1	1
26	Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28					28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29) \$	(54,292)		s	30
50	502101111 (2). (Sum of files 1-27)	(34,272)		9	20

	OHF USE ONLY					
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below. (See instructions.)

				-	
			Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$			31
32	Donated Goods-Attach Schedule*				32
	Amortization of Organization &				
33	Pre-Operating Expense				33
	Adjustments for Related Organization				
34	Costs (Schedule VII)		216,995		34
35	Other- Attach Schedule				35
36	SUBTOTAL (B): (sum of lines 31-35)	\$	216,995		36
	(sum of SUBTOTALS	S			
37	TOTAL ADJUSTMENTS (A) and (B))	\$	162,703		37
	1 3 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	1*	,	l	_

^{*}These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions)

	(Se	e msu ucuons.)		4	3	-	
			Yes	No	Amount	Reference	
3	38	Medically Necessary Transport.			\$		38
3	39						39
4	10	Gift and Coffee Shops					40
4	11	Barber and Beauty Shops					41
4	12	Laboratory and Radiology					42
4	13	Prescription Drugs					43
4	14	Exceptional Care Program					44
4	15	Other-Attach Schedule					45
4	16	Other-Attach Schedule					46
4	17	TOTAL (C): (sum of lines 38-46)			\$		47

Print Other Adjustment

Ending: 1138/90					bette
		Sek. V Line			
NON-ALLOWABLE EXPENSES	Amount	Reference			
The information listed in B13 thru. G43 is from Page 5.			Sub V	Adj. Summary	
1 Buy Care	0		Line 1		
2 Other Care for Outputients	0		Line 2		
3 Generalized Sponored Special Programs	0		Line 3	- 0	
4 Non-Patient Meals			Line 4	- 0	
5 Telephone, TV & Redis in Resident Rooms.	(768)	35	Line 5	- 0	
6 Bosted Facility Space	0	34	Line 6	- 0	
7 Sale of Supplies to Non-Patients			Line 7	-	
5 Laundry for Non-Patients		30	Line 8		
9 Non-Straightline Depreciation			Line 9		
10 Interest and Other Investment Income	1,599	32	Line 10	- 0	
11 Discounts, Allowances, Robates & Refunds	0		Line 18a	_	
12 Non-Working Officer's or Owner's Salary	0	2	Line 11		
13 Sales Tax		22	Line 12 Line 13		
14 Non-Care Related Interest		AZ			
15 Non-Care Related Owner's Transactions	0		Line 14	_	
16 Personal Exposors (Including Transportation)	0	24	Line 15	_	
17 Non-Care Related Fees		20	Line 16		4
15 Fines and Possition	0	24	Line 17		
79 Entertainment	(4,030)		Line 18		
29 Contributions	0	27	Line 19		
21 Owner or Key-Man Incurance 22 Special Loral Fors & Loral Retainers	0	19	Line 20 Line 21	(4,436	
22 Special Legal Fore & Legal Relationers 23 Maloractice Incurance for Individuals		199	Line 22		
2) Majorantee lacarance for ladiciduals. 24 Staff Sale	60,070	27	Line 23		
		27		4400	
25 Fund Raising, Advertising and Promotional 26 Income & H. Personal Promoti Renlacement Taxes	(4,436)	20	Line 24 Line 25	- (4,000	
27 Numer Aidy Transactor for Non-Employees		- 1	Line 26		1
23 Yellow Pare Advertising		- 1	Line 27	(47,07)	
29 Non-Paid Workers		- 1	Line 28	(55,517	
29 New Field Workers 20 Denated Goods		- 1	Line 29	(55.517	
21 Americation Exercis		- 1	Line 10	- 03317	
22 Americation Express	0		Line 31		
11			Line 32	1.00	1
14			Line 33		1
16			Line 34		1
16			Line 35	/368	1
11			Line 36	-	1
14			Line 37	1.225	1
18			Line 38		1
All .			Line 39	- 0	1
41			Line 60		1
42			Line 41	- 0	1
49			Line 42	- 0	1
#			Line 43	- 0	1
45			Line 44	- 0	1
46			Line 45	(54.797	1
41					
di .					
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SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Summary A Facility Name & ID Number FORD COUNTY NURSING HOME # 0000661 Report Period Beginning: 12/01/99 **Ending:** 11/30/00 **SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

Print Summar	Operating Expenses A. General Services	PAGES 5 & 5A	PAGE	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE	SUMMARY TOTALS (to Sch V, col.7)
_			6	θA	0.0	6C 0		0E	0F	0G 0	он 0	61	(to Scn V, col./)
1	Dietary Food Purchase	0				-	0	0	0			Ů	$\begin{array}{c c} & 0 & 1 \\ \hline 0 & 2 \end{array}$
		0	0		0	0	0	0	0	0	0	0	
	Housekeeping Laundry	0	0		0	0	0	0	0	0	0	0	0 3
5	3	0	0		0	0	0	0	0	0	0	0	* -
6		0	0		0	0	0	0	0	0	0	0	0 5
7	Other (specify):*	0	0		0	0	0	0	0	0	0	0	0 7
/	\ 1 \ 2/	ļ			v		•				0		, , ,
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0 8
	B. Health Care and Programs												
9		0	0		0	0	0	0	0	0	0	0	0 9
10	3	0	0		0	0	0	0	0	0	0	0	0 10
	a Therapy	0	0		0	0	0	0	0	0	0	0	0 10a
	Activities	0	0		0	0	0	0	0	0	0	0	0 11
	2 Social Services 3 Nurse Aide Training	0	0		0	0	0	0	0	0	0	0	0 12 0 13
		0	0			v	0				ů		
	Program Transportation	0	0		0	0	0	0	0	0	0	0	0 14
	Other (specify):*	0	0		0	0	0	0	0	0	0	0	0 10
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0 16
	C. General Administration												
17		0	0		0	0	0	0	0	0	0	0	0 17
	B Directors Fees	0	0		0	0	0	0	0	0	0	0	0 18
	Professional Services	0	0		0	0	0	0	0	0	0	0	
	Fees, Subscriptions & Promotions	(4,436)	0		0	0	0	0	0	0	0	0	(4,436) 20
	Clerical & General Office Expenses	0	0		0	0	0	0	0	0	0	0	0 21
	Employee Benefits & Payroll Taxes	0	216,995		0	0	0	0	0	0	0	0	-)
	Inservice Training & Education	0	0		0	0	0	0	0	0	0	0	0 23
	Travel and Seminar	(4,010)	0		0	0	0	0	0	0	0	0	(4,010) 24
	Other Admin. Staff Transportation	0	0		0	0	0	0	0	0	0	0	0 25
	Insurance-Prop.Liab.Malpractice	0	0		0	0	0	0	0	0	0	0	0 26
27	Other (specify):*	(47,071)	0	0	0	0	0	0	0	0	0	0	(47,071) 27
28	TOTAL General Administration	(55,517)	216,995	0	0	0	0	0	0	0	0	0	161,478 28
	TOTAL Operating Expense												
29	(sum of lines 8,16 & 28)	(55,517)	216,995	0	0	0	0	0	0	0	0	0	161,478 29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

- 1. Enter the information on pages 5 and 5A.
- 2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
- 3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
- 4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
- 5. The amounts in the column Q are linked to page 3.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

0000661

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Report Period Beginning:

12/01/99 Ending:

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Summary B 11/30/00

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162,703 45

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SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Facility Name & ID Number FORD COUNTY NURSING HOME

Print Summary													SUMMARY	
	Capital Expense	PAGES	PAGE	TOTALS										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col	.7)
30	Depreciation	0	0	0		0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0		0	0	0	0	0	0	0	0	31
32	Interest	1,593	0	0		0	0	0	0	0	0	0	1,593	32
33	Real Estate Taxes	0	0	0		0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0		0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	(368)	0	0		0	0	0	0	0	0	0	(368)	35
36	Other (specify):*	0	0	0		0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	1,225	0	0	0	0	0	0	0	0	0	0	1,225	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40

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216,995 DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

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1. Enter the information on pages 5 and 5A.

Coffee and Gift Shops

42 Provider Participation Fee

44 TOTAL Special Cost Centers

GRAND TOTAL COST 45 (sum of lines 29, 37 & 44)

43 Other (specify):*

2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.

0

0

0

0

(54,292)

- 3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
- 4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
- 5. The amounts in the column Q are linked to page 4.

PROPERTY IN CONTROL CO

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SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS Page 6A
Facility Name & ID Number FORD COUNTY NURSING HOME # 0000661 Report Period Beginning: 12/01/99 Ending: 11/30/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

YES

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	tne insti	ruction	s for determining costs as specified f	or this form.					
	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
						Percent	Operating Cost	Adjustments for	
Sche	dule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	n
						Ownership		Costs (7 minus 4)	
15	V			s		O viner simp	S	s	15
16	V								16
17	V								17
18	V				-				18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			s			S	s *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Print Previe

- DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.
- 1. Enter the information on pages 5 and 5A.
- 2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
- 3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
- 4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
- 5. The adjustments entered on this page will automatically transfer to the summary pages.

Sum_6A

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

		STATE OF ILLINOI	S				Page 6B
Facility Name & ID Number	FORD COUNTY NURSING HOME	#	0000661	Report Period Beginning:	12/01/99	Ending:	11/30/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with

the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
					Percent	Operating Cost	Adjustments for
Schedule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization
					Ownership	Organization	Costs (7 minus 4)
15 V			S	0		\$	§ 15
16 V							16
17 V							17
18 V							18
19 V		·					19
20 V							20
21 V							21
22 V							22
23 V							23
24 V							24
25 V							25
26 V							26
27 V							27
28 V							28
29 V							29
30 V							30
31 V							31
32 V							32
33 V							33
34 V							34
35 V							35
36 V							36
37 V							37
38 V							38
39 Total			s			\$	\$ * 39

* Total must agree with the amount recorded on line 34 of Schedule VI.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

Print Previe 1. Enter the information on pages 5 and 5A.

- 2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
- 3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
- 4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
- 5. The adjustments entered on this page will automatically transfer to the summary pages.

Sum_6B

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

		STATE OF ILLINOIS				rage oc
Facility Name & ID Number	FORD COUNTY NURSING HOME	# 0000661	Report Period Beginning:	12/01/99	Ending:	11/30/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

YES

NO

 $If yes, costs incurred \ as \ a \ result of \ transactions \ with \ related \ organizations \ must \ be \ fully \ itemized \ in \ accordance \ with$

the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
					Percent	Operating Cost	Adjustments for
Schedule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization
					Ownership	Organization	Costs (7 minus 4)
15 V			S		•	s	S 15
16 V							16
17 V							17
18 V							18
19 V							19
20 V							20
21 V							21
22 V							22
23 V							23
24 V							24
25 V							25
26 V							26
27 V							27
28 V 29 V							28
27 1							29
							30
							31 32
02 ,							
							33
							34 35
35 V 36 V	-				-		35
36 V 37 V	-				-		36
37 V	-				-		38
						_	
39 Total			S			S	\$ * 39

* Total must agree with the amount recorded on line 34 of Schedule VI.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

Print Previe 1. Enter the information on pages 5 and 5A.

- 2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
- 3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
- 4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
- 5. The adjustments entered on this page will automatically transfer to the summary pages.

Sum_6C

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

		STATE OF ILLINOIS					Page 6D
Facility Name & ID Number	FORD COUNTY NURSING HOME	#	0000661	Report Period Beginning:	12/01/99	Ending:	11/30/0

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, YES management fees, purchase of supplies, and so forth.

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with

the instructions for determining costs as specified for this form.

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
						Percent	Operating Cost	Adjustments for	
Sche	dule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	n
					_	Ownership	Organization	Costs (7 minus 4)	
15	V			S			s	S	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V							·	38
39	Total			s			S	s *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

Print Previe 1. Enter the information on pages 5 and 5A.

- 2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
- 3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
- 4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
- 5. The adjustments entered on this page will automatically transfer to the summary pages.

Sum_6D

0000661

Report Period Beginning:

12/01/99

Ending:

11/30/00

Page 7

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5		6	7		8	
						Average Hou	urs Per Work				
					Compensation	Week Dev	oted to this	Compensa	tion Included	Schedule V.	
					Received	Facility and	d % of Total	in Cost	ts for this	Line &	
				Ownership	From Other	Work	Week	Report	ing Period**	Column	
	Name	Title	Function	Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11					·						11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

STATE OF ILLINOIS Page 8

	Facility Name	e & ID Number FORD COU	NTY NURSING HOME		# 0000661 R	eport Period Beginning	: 12/01/99	Ending:	11/30/00	
	VIII. ALLOC	CATION OF INDIRECT COSTS	Show Pgs 8A thru 8	Show Pgs 8E t	hru 8 Hide Pgs	s 8A thru 8				
						Name of Re	lated Organization	Heritage Ente	erprises	
	A. Are the	ere any costs included in this repor	t which were derived fror	n allocations of cen	tral office	Street Addr	ess	115 W. Jeffer	rson	
	or pare	ent organization costs? (See instruc	etions.) YES	NO		City / State		Bloomington,		
						Phone Num		309) 823-71.		
	B. Show the	he allocation of costs below. If nec	essary, please attach worl	ksheets.		Fax Numbe	er <u>(</u>	309) 829-54	77	
			_		_	1	_			
	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1						\$	\$		\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10 11										10
12								-		11 12
13								+		13
14								1		14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24

25

Print Previe

25 TOTALS

FORD COUNTY NURSING HOME

0000661

Report Period Beginning:

12/01/99

Ending:

11/30/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
											Reporting	
					Monthly				Maturity	Interest	Period	
	Name of Lender	Relate		Purpose of Loan	Payment	Date of		unt of Note	Date	Rate	Interest	
		YES	NO		Required	Note	Original	Balance		(4 Digits)	Expense	
	A. Directly Facility Related											
	Long-Term											
1							\$	\$			\$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						\$	\$			\$	9
	B. Non-Facility Related*											
10											(1,593)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
_	TOTALS (line 9+line14)			and hardinated antiques			\$	\$			\$	15

^{*} Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

^{**} If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

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Facility Name & ID Number FORD COUNTY NURSING HOME IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Real Estate Tax accrual used on 1999 report.			\$	0	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applie	. If payment covers more than one year, det	ail below.)	s	0	2
3. Under or (over) accrual (line 2 minus line 1).			\$		3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this a	ccrual on the lines below.)		\$	0	4
 Direct costs of an appeal of tax assessments which has NOT been included in professional (Describe appeal cost below. Attach copies of invoices to support the 			\$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must amount of any direct appeal costs classified as a real estate tax cost plus one-half of any real total REFUND \$ For 19 Tax Year. (Attach a		board's decision.)	s		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of	lines 3 thru 6.		\$		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year: 1995 8		FOR OHF USE ONLY			
1996 9 1997 10	13	FROM R. E. TAX STATEMENT FOR 19	99 \$		13
1998 11 1999 12	14	PLUS APPEAL COST FROM LINE 5	\$		14
	15	LESS REFUND FROM LINE 6	\$		15
	16	AMOUNT TO USE FOR RATE CALCULA	ATION \$		16

NOTES:

- 1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
- 2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.

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	STATE OF ILLINOIS		Page 11
Facility Name & ID Number FORD COUNTY NURSING HOME	# 0000661 Report Period Beginning:	12/01/99 Ending:	11/30/00
V DITH DING AND CENEDAL INFORMATION.	-		

A. BUILDING AND GENERAL INFO	ORMATION:							
A. Square Feet: 33,	,800 B. General Construction Type:	Exterior	Brick/Wood	Frame	Number of Stories			
C. Does the Operating Entity?	XX (a) Own the Facility	(b) Rent from a	Related Organizatio	n.	(c) Rent from Completely Unrelated Organization.			
(Facilities checking (a) or (b) mu	ust complete Schedule XI. Those checking	(c) may complete Schedul	le XI or Schedule XII	-A. See instructions.	Organization.			
D. Does the Operating Entity?	(a) Own the Equipment	(b) Rent equipm	nent from a Related (Organization.	(c) Rent equipment from Completely Unrelated Organization.			
(Facilities checking (a) or (b) mu	ust complete Schedule XI-C. Those checki	ng (c) may complete Scheo	dule XI-C or Schedul	e XII-B. See instructions.				
List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground! (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)								
								
F. Does this cost report reflect any If so, please complete the follow	organization or pre-operating costs which ing:	h are being amortized?		YES	NO NO			
1. Total Amount Incurred:		2	2. Number of Years (Over Which it is Being Ar	nortized:			
3. Current Period Amortization:			4. Dates Incurred:					
	Nature of Costs:							
	(Attach a complete schedule de	tailing the total amount of	f organization and pr	re-operating costs.)				
XI. OWNERSHIP COSTS:								
	1	2	3	4				
A. Land.	Use	Square Feet	Year Acquired	Cost				
		-		3	1 2			
	3 TOTALS			S	3			

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE **REMOVE THE TEXT FROM COLUMN 2 OR 3.**

Show Pgs 12A & 12

Show Pgs 12C and 12

Hide Pgs 12A thru 12

STATE OF ILLINOIS

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Report Period Beginning:

12/01/99 Ending:

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Facility Name & ID Number FORD COUNTY NURSING HOME

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation Including Fixed Equipment (See ins.)

	D. Dullul	ng Depreciation-Including Fixed Equ	uipinent. (See instr	uctions.) Kound	i an numbers to ne	arest dollar.					
	1		2	3	4	5	6	7	8	9	
		FOR OHF USE ONLY	Year	Year	a .	Current Book	Life	Straight Line		Accumulated	
	Beds*		Acquired	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
4	69				\$ 757,502	\$		\$	\$	\$	4
5					650						5
6					955,030						6
7											7
8											8
	Impro	vement Type**									
9	1983	V 1		1983	38,920						9
10	1985			1985	64,800						10
11	1986			1986	8,070						11
12	1987			1987	3,788						12
13	1988			1988	10,194						13
14	1989			1989	2,554						14
15	1990			1990	506						15
16	1991			1991	6,998						16
17	1992			1992	8,653						17
18	1993			1993	4,860						18
19	1995			1995	1,829						19
20	Overhead Lig	hting		1996	5,392						20
21	Overhead Lig	htingResident Rooms		1996	9,941						21
22	A/C Equipme	nt		1996	1,880						22
23	Dietary A/C F	quipment		1997	10,339						23
		A/C Equipment		1998	1,685						24
25	Roof Replacer	nent		1998	10,350						25
26	Drapes			1998	24,467						26
27	Gutters			1998	5,005						27
28	Wall Heater			1998	3,091						28
29	A/C Unit			1998	5,875						29
30	Kitchen Drain			1999	11,070						30
31	Water Condit	ioner		1999	1,672						31
	Door Alarm			1999	2,917						32
33											33
34											34
35	Book Deprecia	ation				18,000		18,000		272,804	35
36	TOTAL (line	es 4 thru 35)			\$ 1958038	\$ 18,000		\$ 18,000	\$	\$ 272,804	36

^{*}Total beds on this schedule must agree with page 2.

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

STATE OF ILLINOIS

0000661

Print Page 12

Report Period Beginning: 12/01/99 Ending: 11/30/00

XI. OWNERSHIP COSTS (continued)

Facility Name & ID Number FORD COUNTY NURSING HOME

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	ing Depreciation-Including Fixed Equ	2	3	4	5	6	7	8	9	\neg
		FOR OHF USE ONLY	Year	Year		Current Book	Life	Straight Line		Accumulated	
	Beds*		Acquired	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
4	Deas		riequirea	Constructed	\$	\$	111 1 0 111 1	\$	\$	\$	4
5					*			-	-	-	5
6											6
7											7
8											8
	Imp	rovement Type**									
	Window Re	placements		2000	2,344						9
10	Windows			2000	5,607						10
	Roof Top A/	C Unit		2000	8,796						11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23 24											23 24
25 26											25 26
27											27
28											28
29											29
30											30
31				-			-				31
32				-			-				32
33				-			-				33
34				-			-				34
35				-			 	1	1		35
	TOTAL (6	nes 4 thru 35)		-	\$ 16,747	s		S	S	S	36
30	TOTAL (II	nes 4 unru 33)			J 10,/4/	3		3	J	J	30

^{*}Total beds on this schedule must agree with page 2.

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE **REMOVE THE TEXT FROM COLUMN 2 OR 3.**

STATE OF ILLINOIS

Print Page 12

Page 12B Facility Name & ID Number FORD COUNTY NURSING HOME 11/30/00 0000661 **Report Period Beginning:** 12/01/99 Ending:

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 1	ing Depreciation-including Fixed Equip	2	3	4	5	6	7	8	9	$\neg \neg$
	1	FOR OHF USE ONLY	Year	Year	7	Current Book	Life	Straight Line		Accumulated	
	D 14	FOR OHF USE ONLY			G 4			Straight Line			
	Beds*		Acquired	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
4					3	3		3	2	3	4
5											5
6											6
7											7
8		1 / 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2									8
	Impi	rovement Type**									4
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29		<u> </u>									29
30		<u>-</u>	<u> </u>								30
31											31
32		<u> </u>									32
33						-					33
34											34
35		<u> </u>									35
36	TOTAL (li	nes 4 thru 35)			\$	\$		\$	\$	\$	36

^{*}Total beds on this schedule must agree with page 2.

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE **REMOVE THE TEXT FROM COLUMN 2 OR 3.**

STATE OF ILLINOIS

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Report Period Beginning:

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Page 12C

| Facility Name & ID Number | FORD COUNTY NURSING HOME

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment, (See instructions.) Round all numbers to nearest dollar.

	D. Duliai	ng Depreciation-Including Fixed E	quipment. (See insti	uctions.) Round		rest dollar.					
	1		2	3	4	5	6	7	8	9	
		FOR OHF USE ONLY	Year	Year		Current Book	Life	Straight Line		Accumulated	
	Beds*		Acquired	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
4			î		\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Impro	ovement Type**									
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30							1		<u> </u>		30
31											31
32											32
33							1				33
34											34
35											35
	TOTAL C'	4.0 25)									
36	TOTAL (lin	es 4 thru 35)			\$	S		\$	\$	\$	36

^{*}Total beds on this schedule must agree with page 2
**Improvement type must be detailed in order for the cost report to be considered complete

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

STATE OF ILLINOIS

Print Page 12

Facility Name & ID Number FORD COUNTY NURSING HOME

0000661

Report Period Beginning:

12/01/99 Ending: 11/30/00

Page 12D

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	D. Dullul	ng Depreciation-Including Fixed E	<u>quipinent, (See insti</u>	1 2	1 an numbers to nea	rest dollar.	6	7	8	9	$\overline{}$
	1	FOR OHF USE ONLY	Year	Year	7	Current Book	Life	Straight Line	0	Accumulated	
	Beds*	FOR OHF USE ONL!			C4			Damariation	A 31:		
	Beas*		Acquired	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
4					3	3		3	3	3	4
5											6
7											7
8											8
0	Impro	ovement Type**									
9	Impre	venicit Type									9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30			<u> </u>								30
31		<u> </u>									31
32		<u> </u>									32
33		<u> </u>									33
34		<u> </u>									34
35											35
36	TOTAL (line	es 4 thru 35)			\$	\$		\$	\$	\$	36

^{*}Total beds on this schedule must agree with page 2.

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

STATE OF ILLINOIS										Page 13		
Facil	ity Name & ID Number FO	RD COUNTY NURSING H	IOME	#	0000661	Report Pe	riod Beginning:	12/01/99	Ending:	11/30/00		
XI. C	WNERSHIP COSTS (continued)											_
	C. Equipment Depreciation-Exclu	iding Transportation. (See i	instructions.)									
	Category of		1			Current Book	Straight Line	4	Component	Accumulated		1
	Equipment		Cost			Depreciation 2	Depreciation 3	Adjustments	Life 5	Depreciation 6		
37	Purchased in Prior Years	\$	133,863			\$	\$	\$		\$	37	1
38	Current Year Purchases		11,726								38	1
39	Fully Depreciated Assets										39	1
40											40	1
41	TOTALS	\$	145,589			\$	s	\$		\$	41	1
	D. Vehicle Depreciation (See instr					10						
	1	Model, Make	Year		4	Current Book	Straight Line	7	Life in	Accumulated		
42	Use	and Year 2	Acquired 3		Cost	Depreciation 5	Depreciation 6	Adjustments	Years 8	Depreciation 9	42	_
42			3			3	3	3		3	42	
44											44	
45											45	
46	TOTALS		\$			\$	s	\$		s	46	_
						L'	- II -	1				
	E. Summary of Care-Related Asso	ets				1				2		
						Reference				Amount		
47	Total Historical Cost									2,120,374	47	
48	Current Book Depreciation		ne 41,col.2 + line 46,col						\$	18,000	48	
49	Straight Line Depreciation		(line 36,col.7 + line 41,col.3 + line 46,col.6) \$ 18,000					49				
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7) \$ 50										
51	Accumulated Depreciation	[(line 36,col.9 + lir	ne 41,col.6 + line 46,col	.9)					\$	272,804	51	

F. Depreciable Non-	Care Assets Include	d in General Ledger	(See instructions.)

	1	2	Current Book	Accumulated	
	Description & Year Acquired	Cost	Depreciation 3	Depreciation 4	
52		\$	\$	\$	52
53					53
54					54
55					55
56					56
57	TOTALS	\$	\$	\$	57

G. Construction-in-Progress

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

- Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.
- ** This must agree with Schedule V line 30, column 8.

FORD COUNTY NURSING HOME

0000661

Report Period Beginning:

(Attach a schedule detailing the breakdown of movable equipment)

12/01/99

Ending: 11/30/00

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XII	. R	FN	TA	Ι. (\mathbf{c}	120	ΓS

Α.	Building	and Fixed	Equipment	(See instructions.)

- 1. Name of Party Holding Lease:
- 2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. YES

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
	Original							
3	Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

10. Effective u	ates of current rentz	ii agi cement
Beginning		
Ending		

11. Rent to be paid in future years under the current rental agreement: 8. List separately any amortization of lease expense included on page 4, line 34. **Fiscal Year Ending Annual Rent**

NO

This amount was calculated by dividing the total amount to be amortized		
by the length of the lease 12	/2001	\$
13.	/2002	\$
9. Option to Buy: YES NO Terms: * 14.	/2003	\$

- B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)
- 15. Is Movable equipment rental included in building rental? YES
- 16. Rental Amount for movable equipment: **Description:**

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

- * If there is an option to buy the building, please provide complete details on attached schedule.
- ** This amount plus any amortization of lease expense must agree with page 4, line 34.

STATE OF ILLINOIS	Page 15
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Facility Name & ID Number FORD COUNTY NURSING HOME # 0000661 Report Period Beginning: 12/01/99 Ending: 11/30/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT		YES 2.	CLASSROOM	PORTION:		3. <u>CLINICAL PORTION:</u>
PERIOD?		NO	IN-HOUSE PR	OGRAM		IN-HOUSE PROGRAM
			IN OTHER FA	CILITY		IN OTHER FACILITY
If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was			COMMUNITY	COLLEGE		HOURS PER AIDE
not necessary.			HOURS PER A	AIDE		
EXPENSES	1	ALLOCATIO	ON OF COSTS	(d)		C. CONTRACTUAL INCOME In the box below record the amount of income y
		1	2	3	4	facility received training aides from other facili
		Fac	ility			
		Drop-outs	Completed	Contract	Total	1 \$
1 Community College Tuition	\$	•	\$	\$	\$	
2 Books and Supplies	\$		1,000	\$	\$ 1,	1,000 D. NUMBER OF AIDES TRAINED
2 Books and Supplies 3 Classroom Wages (a)	\$	•	\$ 1,000 0	\$	\$ 1,	
2 Books and Supplies 3 Classroom Wages (a) 4 Clinical Wages (b)	\$		0	\$	\$ 1,	COMPLETED
2 Books and Supplies 3 Classroom Wages (a) 4 Clinical Wages (b) 5 In-House Trainer Wages (c)	\$			\$	\$ 1,	COMPLETED 1. From this facility
2 Books and Supplies 3 Classroom Wages (a) 4 Clinical Wages (b) 5 In-House Trainer Wages (c) 6 Transportation	S		0	\$	\$ 1,	COMPLETED 1. From this facility 2. From other facilities (f)
2 Books and Supplies 3 Classroom Wages (a) 4 Clinical Wages (b) 5 In-House Trainer Wages (c) 6 Transportation 7 Contractual Payments	\$		0	\$	s 1,	COMPLETED 1. From this facility 2. From other facilities (f) DROP-OUTS
2 Books and Supplies 3 Classroom Wages (a) 4 Clinical Wages (b) 5 In-House Trainer Wages (c) 6 Transportation	\$		0	S S		COMPLETED 1. From this facility 2. From other facilities (f)

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Report Period Beginning:

Facility Name & ID Number

FORD COUNTY NURSING HOME

12/01/99 Ending:

Page 16 11/30/00

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
		Schedule V	Staff		Outsid	Outside Practitioner				
	Service	Line & Column	Units of	Cost	(other t	han consultant)	(Actual or)	Total Units	Total Cost	
		Reference	Service		Units	Cost	Allocated)	(Column 2 + 4)	(Col. $3 + 5 + 6$)	
1	Licensed Occupational Therapist	10a/3	hrs	\$		S 0	\$		S	1
	Licensed Speech and Language									
2	Development Therapist	10a/3	hrs			0				2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a/3	hrs			0				4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
			# of							
9	Pharmacy	39/3	prescrpts							9
	Psychological Services									
	(Evaluation and Diagnosis/									
10	Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Lab	39/3				144			144	13
14	TOTAL			\$		\$ 144	\$		\$ 144	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

pt adj	0
st adj	0
Ot adj	0
drugs	0

0000661 Report Period Beginning: (last day of reporting year) As of 11/30/00

		1		2 After	
		O	perating	Consolidation*	
	A. Current Assets				
1	Cash on Hand and in Banks	\$	97,287	\$	1
2	Cash-Patient Deposits		25,248		2
	Accounts & Short-Term Notes Receivable-				
3	Patients (less allowance)		297,588		3
4	Supply Inventory (priced at)				4
5	Short-Term Investments				5
6	Prepaid Insurance		11,005		6
7	Other Prepaid Expenses				7
8	Accounts Receivable (owners or related parties)		30,264		8
9	Other(specify):				9
	TOTAL Current Assets				
10	(sum of lines 1 thru 9)	\$	461,392	\$	10
	B. Long-Term Assets				
11	Long-Term Notes Receivable				11
12	Long-Term Investments				12
13	Land		0		13
14	Buildings, at Historical Cost		55,346		14
15	Leasehold Improvements, at Historical Cost				15
16	Equipment, at Historical Cost		371,281		16
17	Accumulated Depreciation (book methods)		(272,804)		17
18	Deferred Charges				18
19	Organization & Pre-Operating Costs				19
	Accumulated Amortization -				
20	Organization & Pre-Operating Costs				20
21	Restricted Funds				21
22	Other Long-Term Assets (specify):				22
23	Other(specify):		0		23
	TOTAL Long-Term Assets				
24	(sum of lines 11 thru 23)	\$	153,823	\$	24
	TOTAL ASSETS				
25		en.	(15.315	Φ.	25
25	(sum of lines 10 and 24)	\$	615,215	\$	25

		1 O ₁	perating	2 A Cons	After olidation*
	C. Current Liabilities				
26	Accounts Payable	\$	91,301	\$	26
27	Officer's Accounts Payable				27
28	Accounts Payable-Patient Deposits				28
29	Short-Term Notes Payable				29
30	Accrued Salaries Payable		189,998		30
	Accrued Taxes Payable				
31	(excluding real estate taxes)		0		31
32	Accrued Real Estate Taxes(Sch.IX-B)		0		32
33	Accrued Interest Payable		0		33
34	Deferred Compensation				34
35	Federal and State Income Taxes				35
	Other Current Liabilities(specify):				
36			6,315		36
37					37
	TOTAL Current Liabilities				
38	(sum of lines 26 thru 37)	\$	287,614	\$	38
	D. Long-Term Liabilities				
39	Long-Term Notes Payable				39
40	Mortgage Payable		0		40
41	Bonds Payable				41
42	Deferred Compensation				42
	Other Long-Term Liabilities(specify):				
43					43
44					44
	TOTAL Long-Term Liabilities				
45	(sum of lines 39 thru 44)	\$		\$	45
	TOTAL LIABILITIES				
46	(sum of lines 38 and 45)	\$	287,614	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$	327,601	s	47
40	TOTAL LIABILITIES AND EQUITY				40
48	(sum of lines 46 and 47)	\$	615,215	\$	48

12/01/99

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Ending:

*(See instructions.)

Report Period Beginning: 12/01/99

11/30/00

Ending:

FORD COUNTY NURSING HOME #

Facility Name & ID Number FORD COUNTY NUI
XVI. STATEMENT OF CHANGES IN EQUITY

7 11 10	JES IN EQUIT I				1
			1 Total		
1	Balance at Beginning of Year, as Previously Reported	s	503,187	1	
2	Restatements (describe):	J	303,107	2	-
3	,			3	
	audit Adjustment		0	Ľ.	
4				4	-
5				5	
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$	503,187	6	
	A. Additions (deductions):				
7	NET Income (Loss) (from page 19, line 43)		(175,586)	7	
8	Aquisitions of Pooled Companies			8	
9	Proceeds from Sale of Stock			9	
10	Stock Options Exercised			10	
11	Contributions and Grants			11	
12	Expenditures for Specific Purposes			12	
13	Dividends Paid or Other Distributions to Owners	()	13	
14	Donated Property, Plant, and Equipment			14	
15	Other (describe)			15	1
16	Other (describe)			16	
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$	(175,586)	17	
	B. Transfers (Itemize):				
18				18	
19				19	
20				20	1
21				21	1
22				22	1
23	TOTAL Transfers (sum of lines 18-22)	\$		23	1
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$	327,601	24	*
					•

^{*} This must agree with page 17, line 47.

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue		Amount	
	A. Inpatient Care			
1	Gross Revenue All Levels of Care	\$	1,927,613	1
2	Discounts and Allowances for all Levels		(64,652)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$	1,862,961	3
	B. Ancillary Revenue			
4	Day Care		0	4
5	Other Care for Outpatients			5
6	Therapy		0	6
7	Oxygen			7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$		8
	C. Other Operating Revenue			
9	Payments for Education			9
	Other Government Grants			10
11	Nurses Aide Training Reimbursements			11
12	Gift and Coffee Shop		(172)	12
13	Barber and Beauty Care		0	13
	Non-Patient Meals			14
	Telephone, Television and Radio			15
16	Rental of Facility Space		0	16
17	Sale of Drugs		0	17
18	Sale of Supplies to Non-Patients			18
19	Laboratory			19
20	Radiology and X-Ray		210	20
	Other Medical Services		218	21
	Laundry	_	16	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	46	23
2.4	D. Non-Operating Revenue			- 24
	Contributions		0	24
	Interest and Other Investment Income***			25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$		26
25	E. Other Revenue (specify):****			25
27	Settlement Income (Insurance, Legal, Etc.)			27
28			0	28
28a				28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$		29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$	1,863,007	30

		-	
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	\$ 534,354	31
32	Health Care	1,031,036	32
33	General Administration	455,957	33
	B. Capital Expense		
34	Ownership	16,818	34
	C. Ancillary Expense		
35	Special Cost Centers	428	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,038,593	40
41	Income before Income Taxes (line 30 minus line 40)**	(175,586)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (175,586)	43

*	This must	agree with	page 4, l	line 45,	column 4.

**	Does this agree with	taxable income (loss) per Federal Income
	Tax Return?	If not, please attach a reconciliation

^{***} See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

^{****}Provide a detailed breakdown of "Other Revenue" on an attached sheet.

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33

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Facility Name & ID Number FORD COUNTY NURSING HOME

Report Period Beginning:

12/01/99

Ending:

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1 Director of Nursing			s 41,584	\$	1
2 Assistant Director of Nursing			0		1
3 Registered Nurses			162,816		
4 Licensed Practical Nurses			147,662		-
5 Nurse Aides & Orderlies			391,995		
6 Nurse Aide Trainees			0		
7 Licensed Therapist					1
8 Rehab/Therapy Aides			0		7
9 Activity Director					1
10 Activity Assistants			40,277		1
11 Social Service Workers			20,426		1
12 Dietician					1
13 Food Service Supervisor					1
14 Head Cook					1
15 Cook Helpers/Assistants			212,678		1
16 Dishwashers					1
17 Maintenance Workers			33,633		1
18 Housekeepers			74,881		1
19 Laundry			16,521		1
20 Administrator			49,173		2
21 Assistant Administrator					2
22 Other Administrative					2
23 Office Manager					2
24 Clerical			34,211		2
25 Vocational Instruction					2
26 Academic Instruction					2
27 Medical Director					2
28 Qualified MR Prof. (QMRP)					2
29 Resident Services Coordinator					2
30 Habilitation Aides (DD Homes)					3
31 Medical Records					3
32 Other Health Care(specify)					3
33 Other(specify)					3

0

1,225,857 * \$

Print Previe

33 Other(specify)

34 TOTAL (lines 1 - 33)

B. CONSULTANT SERVICES

		1	2	3	
		Number	Total Consultant	Schedule V	
		of Hrs.	Cost for	Line &	
		Paid &	Reporting	Column	
		Accrued	Period	Reference	
35	Dietary Consultant		\$		35
36	Medical Director		1,950		36
37	Medical Records Consultant		0		37
38	Nurse Consultant				38
39	Pharmacist Consultant		1,950		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		5,700		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 9,600		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$ 16,430		50
51	Licensed Practical Nurses		5,933		51
52	Nurse Aides		128,109		52
53	TOTAL (lines 50 - 52)		\$ 150,472		53

^{*} This total must agree with page 4, column 1, line 45.

^{**} See instructions.

	FORD COUNTY NUK	ING HOM	Li .	# 00000	01	Keport i er	iou Beginning.	12/01/99 End	ing.	11/30/00
XIX. SUPPORT SCHEDULES										
A. Administrative Salaries		wnership		D. Employee Benefits and Pa				Fees, Subscriptions and Prom	otions	
Name	Function	%	Amount	Descrip		Amou		Description		Amount
Doug Harridge	Administrator		49,173	Workers' Compensation Insu		\$ 20,00			\$	0
				Unemployment Compensation	n Insurance	5,10		ng: Employee Recruitment		6,745
				FICA Taxes		93,7		are Worker Background Che	ck	
				Employee Health Insurance		122,4	,	# of checks performed)	516
				Employee Meals				office Allocation		
	<u> </u>			Illinois Municipal Retiremen	t Fund (IMRF)*	103,2		nal Advertising		373
				Employee Hepatitis Vaccine			0 Public Re			4,063
TOTAL (agree to Schedule V, line				Employee Benefits -		(38		Subscriptions		3,628
(List each licensed administrator s	separately.)	<u> </u>	49,173	Employee Benefits - central o	ffice		License a	nd Fees		1,051
B. Administrative - Other										
								iblic Relations Expense		(4,063)
Description			Amount					n-allowable advertising	(_	0
		S					Y	llow page advertising		(373)
				TOTAL ((. C.L. I.L.)	7	6 24414	97	TOTAL ((. C.L. W	•	11.040
				TOTAL (agree to Schedule	ν,	\$ 344,18	87	TOTAL (agree to Sch. V,	\$_	11,940
TOTAL (17 2\			line 22, col.8)			0.61.1	line 20, col. 8)		
TOTAL (agree to Schedule V, line		3		E. Schedule of Non-Cash Con	npensation Paid		G. Sched	ule of Travel and Seminar**		
(Attach a copy of any managemen	t service agreement)			to Owners or Employees				D 1.11		
C. Professional Services	m.				** "			Description		Amount
Vendor/Payee	Туре	e	Amount	Description	Line #	Amou			•	
Heritage Enterprises	Management Fees	<u> </u>	111,.00			\$	Out-oi-S	ate Travel	>_	
Ford County	Payroll Processing		5,500							
Accu-Med Services	Consulting		2,684				In-State	P		
							In-State	i ravei		2.007
										2,806
										10
							Seminar	Ermanga		3,185
							Non Allov			
						-		office Allocation		(4,010)
							Centrai C	mee Anocation		
						-	Entortoi	ment Expense	_ , -	
TOTAL (agree to Schedule V, line	19 column 3)			TOTAL		8	Entertain	(agree to Sch. V,	_ ' -	
	17, (01411111 3)			IOIAL		Ψ		(agree to sen. v,		
(If total legal fees exceed \$2500 att		_	119,589				TOTAL	line 24, col. 8)	_	1,999

Report Period Beginning:

12/01/99

Ending:

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XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3). (See instructions.)

Facility Name & ID Number FORD COUNTY NURSING HOME

	1	2	3	4	5	6	7	8	9	10	11	12	13
		Month & Year						Amount of	Expense Amorti	zed Per Year			
	Improvement	Improvement	Total Cost	Useful									
	Type	Was Made		Life	FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		s		s	s	s	s	s	s	s	s	s

	Name & ID Number FORD COUNTY NURSING HOME	#	0000661	Report Period Beginning:	12/01/99	Ending:	11/30/00
XX. GE	NERAL INFORMATION:						
(1)	Are nursing employees (RN,LPN,NA) represented by a union?	(13)		supplies and services which are of the Public Aid, in addition to the daily ra			
(2)	Are there any dues to nursing home associations included on the cost report? If YES, give association name and amount. Illinois Healthcare Association		in the Ancillary Se	ction of Schedule V? yes	_		
(3)	Did the nursing home make political contributions or payments to a political action organization? yes If YES, have these costs been properly adjusted out of the cost report? yes	(14)	the patient census l	building used for any function other to isted on page 2, Section B? no building used for rental, a pharmacy, axplains how all related costs were all	day care, etc.)	For exampl If YES, attac	e,
(4)	Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity?	, ,	Indicate the cost of on Schedule V. related costs?		ssified to emplo meal income be the amount. \$	en offset aga	
(5)	Have you properly capitalized all major repairs and equipment purchases wes What was the average life used for new equipment added during this period? yes 7 years	(16)	Travel and Transpo	ortation ncluded for out-of-state travel?	no		
(6)	Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. 5,000 Line		If YES, attach a	complete explanation. eparate contract with the Department If YES, please indicate the a	t to provide med		
(7)	Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.		program during c. What percent of	this reporting period. \$ all travel expense relates to transporting elogs been maintained? yes			
(8)	Are you presently operating under a sale and leaseback arrangement? If YES, give effective date of lease.		e. Are all vehicles times when not i	stored at the nursing home during the	C		
(9)	Are you presently operating under a sublease agreement? YES xx NO						no
(10)	Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO xx If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.		Indicate the a	mount of income earned from p a during this reporting period.	roviding such	l	
		(17)	Firm Name: Br	performed by an independent certifie ay, Drake, Guthrie and Richardso	n	The instruc	tions for the
(11)	Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$\frac{37,778}{V}\$ This amount is to be recorded on line 42 of Schedule V.		cost report require been attached?	that a copy of this audit be included no If no, please explain.	Not complet		
(12)	Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? no If YES, attach an explanation of the allocation.	(18)	Have all costs which out of Schedule V?	th do not relate to the provision of lo yes	ng term care be	en adjusted o	out
	· · · · · · · · · · · · · · · · · · ·	(19)	performed been att	re in excess of \$2500, have legal involution ached to this cost report? yes did a summary of services for all architectures.		•	ices

STATE OF ILLINOIS

Page 23

-	Description PETTY CARR	GL C	-	Total Cold	CEAN E pg I Adjust Line 6 Amount	4 100*	HISCARIUS 41	e e	
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